INSURING FOR GROUP PRACTICE: THE ROLE OF BLUE CROSS*

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WE have reached the point where we can no longer respond to expressions of concern or alarm about rising health costs with "that is the way it is when you provide personal health service" or "you can't automate health care the way you can a business." The cost is too great. And there is too great a variation between costs paid by different people in different areas into different systems without any appreciably different effect on the level of health. It is no longer acceptable to have an apparently satisfactory health system costing some people two or three times as much as it does others for the same level of satisfaction.

Examination of differences in costs and patterns of care shows wide variation in the two areas of greatest expenditure: the services of hospitals and of physicians in acute cases.

An initial review of comprehensive capitation group practice presents startling economies in hospital care—economies so great as to pay a substantial portion of the cost of comprehensive care by physicians. It is not certain how much of the saving is then used with extra time on the part of the physicians, but the halving of the number of hospital days required in acute cases per thousand persons per year from 1,000 to 500 $60-days means a saving in hospital costs alone of $30,000,000 per year on a base of a million people.

The main point is that this kind of result is achieved only where the total spectrum of care is under a controlled discipline. And this discipline or balance is maintained through professional decisions. The conclusion may well be drawn that there is also more effective use of a physician's time.

As pointed out in the Gorham report, a 4 per cent increase in

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productivity by the average physician would be equivalent to graduating 11,700 more doctors. This exceeds the yearly output of all our medical schools and increases productivity without educational expense now, not 10 years from now. A health system which has produced such apparently spectacular results in institutional care in our overinstitutionalized country—even though it is only in isolated portions of the country—should not be just exhibited under glass or studied ad nauseum.

The need to move boldly into new and promising areas is imperative. Blue Cross accepts the responsibility of assuring that group practice exists effectively on a substantial scale in a number of metropolitan areas. Blue Cross is determined to provide, wherever possible, a dual choice for its subscribers between traditional patterns and the pattern of group practice.

Blue Cross has already made application to the Department of Health, Education, and Welfare to study differential use and costs under fee-for-service and group practice where Blue Cross handles the hospital bills for each. Blue Cross is alert to the fact that young medical members of staffs around the country have expressed interest in some form of group practice. Blue Cross also recognizes that there are many definitions of group practice. It is working on a variety of programs within the general framework called group practice—and it will take the half loaf, as compared to full capitation. The important act is to improve the organization.

Money alone is not an automatic solution to the establishment of new forms of providing health care. Management know-how, merchandising effectiveness, and a broad base of existing business are also required.

Blue Cross can provide the managerial know-how, it can provide contracts, it can work with hospitals, it can provide the dual choice. And, like individuals who make up group practice, Blue Cross is service-oriented, control-oriented, community-oriented. In addition, it covers the entire nation; it has great variety; it is large enough to test different systems honestly. It is willing to put its money where it really counts—locally and in benefits.

The very first step in establishing group practice on a significant level must be the demolition of the legal bars erected in most states. Then will come organization and operation which will provide not only dual choice for the patient, but genuine bench marks for the com-

munity measurement of quality and quantity of care.

The business of the organization of medical care cannot be improved with slogans such as "freedom of choice." This is not the time to use brave public relations slogans 20 years out-of-date: this is the time for demonstrations on a major scale. In the present mood of Blue Cross—which has a great vitality—we expect to remove guild-perpetuating laws, the confusion of ethics with money, or the parading of professional interest against the community interest or any other artificial deterrent to the improvement of care.